



As such, it is disappointing that Hamilton and associates did not present any age-specific smoking results. The reported incidences (in Table 3) represent an average of high rates of starting smoking in teenagers and of low rates in older respondents. It is also disappointing that the survey collected no data on children under age 15. Data from surveys such as the Ontario Health Survey suggest that up to 50% of smokers start smoking by that age.¹ Hence, the Statistics Canada survey may have missed important trends in the rates of starting smoking.

I am also concerned that the survey used a panel design rather than interviews of separate groups of subjects at each time point. The panel design has 2 implications. First, a bias may be introduced into the subjects' responses. For example, subjects may be more reluctant to admit having started smoking in later rounds because the repeated questions about smoking may have made them self-conscious about the fact that smoking is socially undesirable. Second, people who had started smoking in an earlier round would not be able to start again. Hence, the rates of starting smoking could underestimate the true rates in the Canadian population.

Because of these concerns, I think we should not be too reassured by the observation that smoking prevalence continued to drop despite the tobacco tax cut. The cautions proposed by Hamilton and associates need to be emphasized and more aggressive legislative actions pursued to prevent children from starting to smoke.

Nicholas Birkett, MD, MSc
Department of Epidemiology
and Community Medicine
University of Ottawa
Ottawa, Ont.

Reference

1. Birkett NJ. *Smoking prevalence in Ontario: a reconstructed cohort analysis of the 1990 On-*

tario Health Survey for people born between 1940 and 1975 [working paper]. Ontario Tobacco Research Unit; 1996.

[The authors respond:]

Dr. Birkett notes that we did not report age-specific smoking results. The analysis we reported is the initial step in a study funded by the National Health Research and Development Program in which we are studying the impact of a number of factors on cigarette smoking; these factors include tobacco taxes, age, education, income and family composition. Given the potential correlation among sociodemographic variables, we were reluctant to report age-specific results at this stage.

The survey indicates a difference of 0.25 percentage points in smoking uptake immediately after the 1994 tax rollbacks between adults (20 years of age and older) living in provinces with tax cuts and those living in provinces without tax cuts (1.77% v. 1.52%). In contrast, the difference in smoking uptake among youth (those 15 to 19) between provinces with and without tax cuts is 1.53 percentage points (5.62% v. 4.09%). Thus, the fact that this survey does not contain information on even younger Canadians may underestimate the overall impact of the tax cuts on smoking behaviour. However, we prefer to reserve judgement on this issue until we have had the opportunity to conduct an in-depth multivariate analysis.

Birkett is also concerned that repeated surveying of subjects may have caused them to be more reluctant to admit that they had started smoking in later rounds of the survey, leading to further underestimates of smoking behaviour. We know of no studies that identify such behaviour. In addition, this behaviour would have had to occur at systematically different rates in provinces with tax cuts and in those without tax cuts to bias our estimates. Birkett's claim that people who had started smoking in an earlier

round would not be counted as new smokers if they quit and then started again during the survey is incorrect.

Although we found a decrease in smoking prevalence in all provinces during the survey, it was never our intention to understate the negative health implications of the 1994 tobacco tax rollback. Our results imply that the tobacco tax cuts slowed declines in Canadian smoking prevalence substantially. We also noted the importance of analysing the impact of these cuts on youth. As an initial examination of this issue, the descriptive statistics noted above certainly support Birkett's argument for more aggressive legislative actions to prevent children from starting to smoke.

Vivian H. Hamilton, PhD

Carey Levinton, MSc

Yvan St-Pierre, MSc

Centre for the Analysis of Cost-Effective Care

Division of Clinical Epidemiology
Montreal General Hospital
Montreal, Que.

Franque Grimard, PhD

Department of Economics
McGill University
Montreal, Que.

CMPA fees

Patrick Sullivan's recent article ("Dubin calls on CMPA to eliminate fee differentials, adopt flat fee for all physicians," *Can Med Assoc J* 1997;156:685-7) made me recall the "old days," when the Ontario Medical Association tariff and economics committees distributed the allocated percentage of fee increases to the different specialties. A portion of these increases was reserved to compensate specialties facing higher Canadian Medical Protective Association (CMPA) fees.

This meant that Ontario physicians were subsidizing the increased CMPA fees of certain specialties by having a smaller percentage allocated